

SIX STEPS TO MANAGING DEMAND IN ADULT SOCIAL CARE - A PERFORMANCE MANAGEMENT APPROACH

John Bolton and Philip Provenzano, March 2017



Contents

Introduction	2
Part One – Six “Steps” to Managing Demand	5
Step 1 - Managing Demand through the Front Door of the Council.....	5
Step 2 - Managing Demand from the Acute Hospitals	7
Step 3 - Effective short-term interventions for people from the community	12
Step 4 – Designing the care system for people with long term care and support needs.....	15
Step 5 - Developing a workforce to manage demand	18
Step 6 - Governance and management arrangements to sustain improvements	19
Part Two – Managing Demand – Managing Performance	21
Conclusion	24
Appendix 1 – Objectives and Performance Measures	25

Introduction



In the paper “Predicting and Managing Demand in Adult Care” published by the Institute of Public Care,¹ John Bolton illustrates a range of different ways in which Councils might approach managing demand for social care. The paper was built on the evidence from Councils that have been observed and written up – mostly in the Local Government Association’s Adult Social Care Efficiency Programme (ASCE)² and its successor – The Care and Health Improvement programme (CHIP)³. One lesson from the report is that Councils ought to be able to systematically measure and monitor activities so that they understand whether they are delivering individual and service outcomes required to meet their strategic objectives.

This paper, written jointly by John Bolton and Philip Provenzano at the Institute of Public Care, looks to expand the content of the above paper and suggests that improving the performance management of strategic objectives might assist Councils in delivering the changes required⁴. It comprises the personal views of the authors.



In our work with Councils, there are two common features often missing from their approach to the delivery of social care. First, is a clear strategy on managing demand, and second is the analysis of data required to understand the impact of that strategy. This paper aims to assist with both of these tasks by advocating the need for clearly articulated strategic objectives and a systematic performance focus for the six areas below (which were all identified in the earlier paper Predicting and Managing Demand in Adult Care) as being critical to the way in which demand is managed by social care.

¹ https://ipc.brookes.ac.uk/publications/Predicting_and_managing_demand.html

² <http://www.local.gov.uk/documents/10180/11779/LGA+Adult+Social+Care+Efficiency+Programme+-+the+final+report>

³ <http://www.local.gov.uk/chip>

⁴ This paper should be considered in the light of the more detailed evidence produced in “Predicting and Managing Demand”

- 1. Managing demand through the front door of the Council** - How is the front-end of the service set up in relation to handling initial enquiries, and how many of these can be resolved by the staff who handle them?
- 2. Managing demand from acute hospitals** - How is the response from the acute hospital managed and what are the outcomes for older people?
- 3. Effective short-term interventions for people in the community** - How are the initial offers of help to people designed, and can they respond with short term help that may reduce or eliminate the need for longer term solutions e.g. access to re-ablement?
- 4. Designing the care system for people with long term needs** - How does the way in which we assist people help them gain opportunities for greater independence in the longer term? How do we assist people to manage their long-term conditions?
- 5. Developing a workforce to manage demand** - To what extent has the work force been commissioned/managed (trained) to deliver the best possible outcomes for citizens at all of these different levels?
- 6. Governance and management arrangements to sustain improvements** - How are managers in the authority and commissioned providers held to account for the delivery of the desired outcomes from the care system?

This paper explores each of these areas in turn and suggests the type of performance (based on examples of practice that been observed in at least one setting) that might be expected if demand is being effectively managed. It is important to note that:

- the figures in some examples may still need to be further tested and refined. The paper proposes them as a starting point;
- each Council (possibly in conjunction with health colleagues) will need to consider what works for them;
- there may be other factors that require more exploration.

We have purposely set the paper in the context of revitalising the practice and discipline of effective “performance management” on the basis that “what gets measured gets done!” Therefore, doing performance management “well” can help organisations in the pursuit of efficiency and effectiveness in that it helps to:

- distinguish between success & failure;
- identify success and reward it;
- identify success and replicate it;
- identify failure and correct it;
- demonstrate results and build support.

However, in our experience, whilst many well-intended processes for the gathering of evidence to explore or validate performance are initially well-attended to, they fall by the wayside; due to the resources required to collect and make sense of the data or the failure to make decisions on how to improve quality and performance based on the data. Therefore, we suggest underpinning the evidence gathering approach described in the paper with the following principles:

- To take a pragmatic, focused approach using existing processes and arrangements where possible.
- To ensure partners/stakeholders are engaged in the process.
- To take a change management approach recognising that it is a changing and developing agenda.
- To ensure and create a learning culture.
- To learn from research and best practice from elsewhere.

Councils who do want to manage demand should be measuring for their own use how successful they are in meeting their stated objective on a range of different fronts. Managing and understanding this impact through an effective performance management approach, the outcomes from the local care system are a critical part of this process.

Professor John Bolton and Philip Provenzano
March 2017

Part One – Six “Steps” to Managing Demand

Over the last 30 years, IPC have worked with a significant number of public care organisations to develop or improve their performance management arrangements. A key underpinning principle for the development of these arrangements has been their mantra that ‘you cannot have good performance without achievement...achievement is not possible without measurement...and measurement is pointless without the context of objectives.’ We have used the essence of this discipline as the basis for transforming a set of “good ideas” into a set of organisational intentions that are systematically monitored and reviewed. Therefore, in this section, we revisit the six areas identified above and for each offer:

- A set of strategic objectives that a council may consider in setting out its strategic direction⁵ for adult social care. These objectives or statements of intent describe what good practice might look like if a council was looking to best manage demand from customers whilst still looking to deliver the best possible outcomes.
- A rationale (based on evidence detailed in previous reports) which considers the approach that may be adopted to deliver the stated objectives.
- A set of measures that may assist the council in understanding how far it is progressing in meeting those stated objectives. In this way managers, front line workers and providers of services could all be held to account for their contribution to those objectives.

Step 1 - Managing Demand through the Front Door of the Council

How is the front-end of the service set up in relation to handling initial enquiries and how many of these can be resolved by the staff who handle them?

Rationale

The first point to note is that, in general, adult social care can be characterised as having two front doors leading to potential demands on its services. These both need to be managed and may require some different approaches. Firstly, there is a front door that responds to requests for help from the public, from the local community, from relatives and other community based services e.g. GPs and Nurses. The second front door is from the acute hospital that is covered in the next section.

For adult social care, there are very few visitors who come direct to a council for help, so most new requests are made over the phone or web-based systems. (Most are made by third parties and not by the people seeking help for themselves). The majority of the requests for help through this front door will not require an immediate social work assessment or even a response from social care. They can include requests for financial advice (including help with benefits and pensions) and help with housing; with nuisance neighbours; for people who do not know they are being referred; to complete forms and documents; advice on community activities; and a whole range of requests that require a response but are not within the main purpose of social care. Councils will set up their initial contact arrangements to address their concerns and in many situations find speedy resolution.

⁵As one example - See London Borough of Hackney - Our Adult Social Care Commitment Statement

The evidence from the national returns⁶ suggests that just over half of the requests to Councils that have been handled by adult social care staff will not require a social work assessment, because either they could be sign-posted elsewhere for help, or because there were no identified social care needs.

The Local Government Association's Adult Social Care Efficiency Programme has identified a number of Councils where the numbers of people being helped in a way that resolves the problems they have at the point of initial contact equates to about 75% of those who had made contact with the council for help from adult social care. The evidence collected shows how they have increased their percentage of people being helped comes from is particularly notable in those Councils where the local contact centre has had a strong focus on the resolution for people's problems and a diversion from formal social care such as in the case studies for North Tyneside; South Tyneside and Shropshire.

Some Councils have looked to reduce their costs at the front door by purchasing software that enables citizens to self-assess and look for ways of meeting their care needs on line. There are a number of software packages on the market to assist Councils with this. Some of these focus on the entitlement the person may have to a personal budget - the assessment tool will tell a person if they have eligible needs or not. These programmes have a risk that they inadvertently increase demand. Other programmes have a much stronger preventive base to their assessment tool, helping people find solutions in their communities, in the voluntary sector other ideas to find ways of meeting the person's needs. Coventry City Council report that the portal they have put in place for local citizens has been very successful after its recent introduction, with around 90% of those who seek help finding a solution without requiring further assessment from a social care worker (after the first 320 enquiries).

Each of these Councils had a slightly different model for their front door. But, in some cases there were staff employed within the initial contact centre who could work with customers on a short-term basis to assist in finding resolution to their problems. Staff in these Councils are trained and have the confidence to help people find resolution to their problems linked to a good knowledge about what is available in the local community.

A number of councils have now placed their contact centres either within, or very close to, community and voluntary sector groups so that it is easier to access the alternatives that are available to meet people's needs. Other Councils have actually commissioned parts of the voluntary sector to take an active part in helping to manage front line enquiries in such a way that they are not even recorded by the council. We suggest that this is monitored and understood by the council so that it is clear on the impact of such arrangements on demand for social care. One example of diversion at the front line is where the conversation with the person asking for help finds that they are socially isolated and the solution on offer may include the opportunity to receive a visiting/volunteer service.

Of course, the 75% figure may vary according to the way in which contact with the council is structured, and the way in which local data is recorded. One example of this is whether the application from elderly and disabled people for Blue Badges (to assist with parking) is seen as a social care function or a corporate function of the council. Some Councils record quite high demand on their contact centres but this may not accurately reflect people who need social care.

⁶ Information from NHS Digital Community Care Statistics Social Services Activity, England, returns for 2015/16 showed that 57 per cent of requests for support resulted in no direct support from the council. This was split between 524,000 requests resulting in Universal Services/ Signposted to other services and 515,000 requests resulting in no identified needs.

Another way of looking at the impact of the first contact with the public from the community is to consider the number of people who receive a social work assessment but who do not receive any services as a result. It is this cohort who may be helped prior to receiving a full assessment with solutions which rest within their community, their family or within the local voluntary sector, and who do not require a package of formal care. In some Councils, resources are “wasted” on undertaking assessments when there are relatively straight forward solutions available on which front line staff should be able to advise. Councils who are looking to divert people at their front door are not deciding who gets help by applying eligibility thresholds. The focus is to listen and talk with the customers to identify solutions that are available locally, which are not usually accessing formal social care services. It is good practice, for councils to have a follow up conversation with the people they have helped. This should ensure that the solutions offered have helped people to find resolution to their problems. This is best carried out through a sample of those who have been helped.

Objective 1

There is an effective council front door for finding solutions for people and their problems that can demonstrate its impact in terms of diversions from formal care and delivering good outcomes.

Performance Measures:

For a council wanting to manage performance against this objective, we suggest considering the following measures

- The % of people who have approached the council for help with adult care (or an agency commissioned by the council for that purpose) who go on to receive a full social care assessment.

The figure should preferably be circa 25% of the new enquiries from the community⁷. (There are a number of variable factors here so this may need to be revised in particular circumstances but might be linked to the indicator below. It may also be considering reviewing arrangements if performance is significantly higher than 25%).

- The % of people who have received a full assessment (from the 25% of people cited above) who then go on to receive a package of care.

This figure should be 90% - though the initial service may be help that supports recovery, rehabilitation, recuperation or reablement. (See the next section).

Step 2 - Managing Demand from the Acute Hospitals

How is the response from the acute hospital managed and what are the outcomes for older people?

Rationale

According to the national data, 24% of requests for support for new clients aged 65 and over came through the initial contact centre route of access⁸ (the “second front door”). However, whereas only 25% per cent of people who approach the Council’s initial contact centre from the community are likely to require some form of service, a much higher percentage of older people referred from the acute hospitals are likely to require help, even if a good proportion of this

⁷ This figure (and the one below) does not include requests for help from acute hospitals

⁸ Community Care Statistics Social Services Activity, England, 2015-16

group will only require this for a short time. In many Councils, almost half of the new longer-term work in adult care services comes from the acute sector.

There is much written on the arrangements to assist speedy discharge with plenty of guidance from NHS England, Department of Health and many writers. In our view the messages are all clearly stated in the 2009 Department of Health Guidance – “Half Way Home”⁹.

The current guidance omits the important point that it is the outcomes for the customers that are the most important part of the arrangements rather than solely the speed of discharge. Work undertaken by John Bolton in both Glasgow City and Nottinghamshire County has shown that if the focus on the care and health system is on the best possible outcomes for the patient through the discharge process, then it is more likely that the system will be able to manage the flows of people from discharges and, hence, reduce delays¹⁰.

There are a number of different circumstances that patients might experience at the point of discharge:

1. Require minimal and practical help to get home and start functioning successfully (probably can be supported by a volunteer).
2. Require support for a short time whilst they “find their feet” and work on the programme set by a therapist (need a little amount of care but emphasis on managing self-recovery).
3. Require support through a re-ablement based package of care with a focus on a period of recovery which will vary according to the person and their condition;
4. Assessment is uncertain as to the individual’s ability to manage (after a period of re-ablement).
5. Still have a serious condition where the prognosis is poor and need good quality nursing and care (including dementia care).
6. Require an assessment of their mental health (which is best not completed in an acute setting).
7. Require on going nursing care and a “continuing care” health assessment.

From our work with Councils across the UK there appear to be a number of key considerations when planning for discharges:

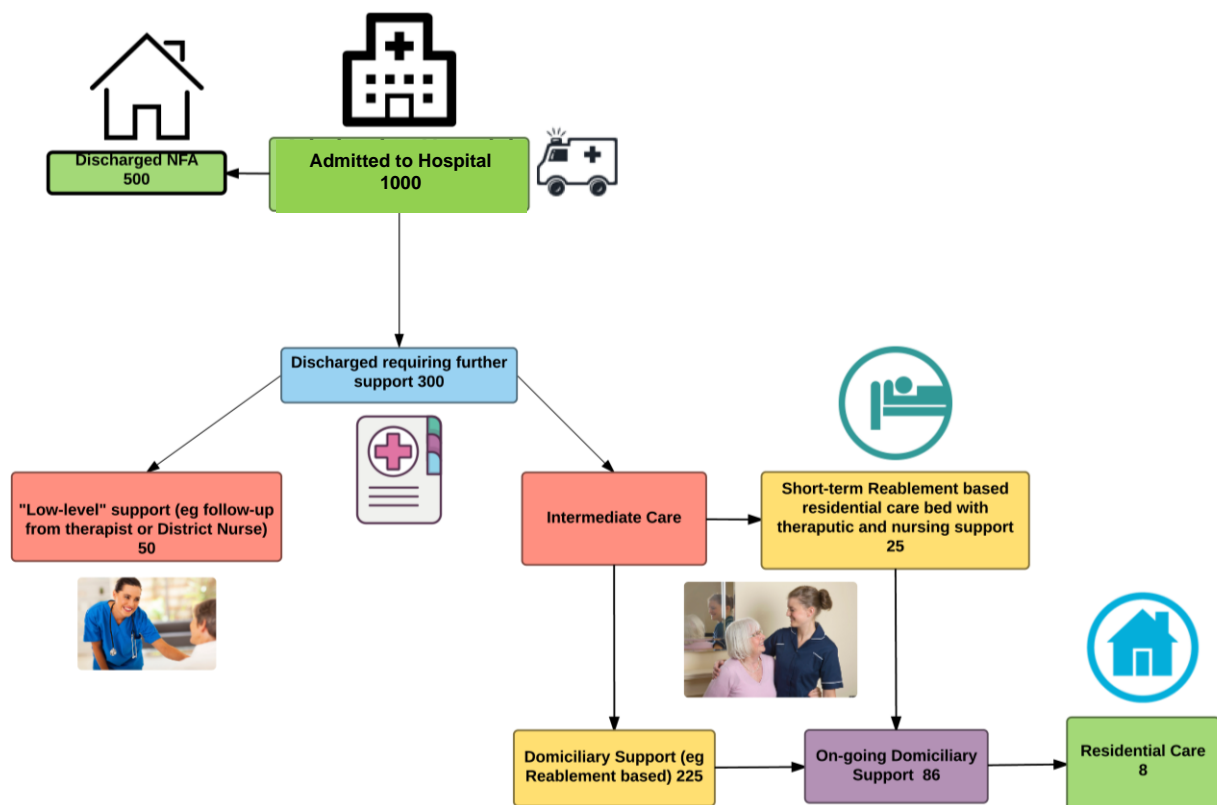
1. The services that should be available at the point of discharge should in most cases offer short-term help that focuses on supporting recovery and recuperation. These services must involve therapists, nurses and care workers, all of whom share the outcomes focus.
2. It is important to have a good understanding of the patterns of demand so that, at the point of discharge, a range and sufficient supply of the required services is readily available, including some residential intermediate care beds as well as support in the community.
3. As the needs of some people are frequently overestimated by some professionals at the point of discharge, a more timely and systematic mechanism is needed that identifies people who, when in the community, require less or no further support.
4. Many delays are caused by patients waiting for an “assessment”. Those planning discharges should always consider whether an assessment in hospital is the best place and whether many of the important aspects of an assessment could take place in a setting outside hospital – preferably at the person’s own home.

⁹ Intermediate Care – Halfway Home Updated Guidance for the NHS and Local Authorities 2009 (UK Government Web Archive).

¹⁰ Findings from unpublished work of John Bolton with a number of local authorities across the UK

We suggest, therefore, that health and care systems need to review on a regular basis the impact of both intended and unintended outcomes the above considerations appear to have. Places that might appear to achieve speedy discharge may actually produce poor outcomes for older people. These often come at a high cost to the Councils and CCGs; we have observed that in many situations, the outcomes are not measured.

The diagram below attempts to show in picture form the flow of patients through the health (and care) system. It is the management of flow through the system that is important¹¹:



Understanding which patient needs the right level of care at the point of discharge is the key consideration for those supporting the process. This is not the time for people to make longer-term assessments. There may be patients in the final stages where the start of a longer-term assessment may begin in the hospital, but for all of the others an intermediate care solution has to be the answer.

The evidence from the study undertaken by Newton Europe for the Local Government Association¹² suggests that one in five people leaving hospital are over-prescribed the level of care they require. Our direct work with Councils leads us to believe that about one third of the direct permanent admissions to residential care from acute hospital beds are avoidable (though this does vary from place to place and can be higher). This is one of the areas in many Councils where there is significant scope to help manage demand in social care.

¹¹ The figures are indicative and need to reflect actual data for each acute hospital and local variation in the service model, i.e. in some county areas there may be community hospitals, whereas, these may not be a feature in some in larger towns and cities.

¹² Health and Social Care Efficiency on LGA website: http://www.local.gov.uk/productivity/-/journal_content/56/10180/3371097?_56_INSTANCE_0000_templateId=ARTICLE

The LGA Efficiency Reports demonstrate that the services offered to a person needing care and support at the point of discharge makes a significant difference to their longer-term needs. The study on Kent County Council¹³ showed that for every older person placed in a standard residential care bed on a short term basis around 80% of those people remained in that bed for the rest of their lives. When people with similar assessed needs were placed in an intermediate care bed where there was a focus on helping people's recovery, over 80% returned home. It was not the assessed needs that made the difference but the offer that was available to the patients at the point of discharge.

One problem with many of the current discharge arrangements is that the supply of care – whether residential or domiciliary care – have a mismatch between the needs of the people using the service and the level of care that is offered. With this in mind Leicestershire County Council now review all the care that patients receive within two weeks of discharge. They have found that a significant proportion of people no longer need any care. This then frees up capacity to assist the next set of people needing support (at the point of discharge)¹⁴.

The evidence from John Bolton's work in assisting health and social care with delayed discharges¹⁵ suggests that one of the key factors is managing the flow of patients through the health and care systems. If patients receive the minimum help they require more capacity is then made available. If their needs are overstated and they are assessed either too early or inappropriately then there will be more demand for care. If the right help is not available at discharge this can also lead to higher demands in the longer term. However, it is also worth noting that this is not solely a social care issue. The best outcomes for patients are only likely to be achieved when health services and care services are working collaboratively to deliver the best outcomes for patients. This means that therapists, nurses, General Practitioners and care workers are all supporting people's recovery in the best way for the patients and for their specific condition.

In order to manage the flow of patients, those commissioning services need to ensure availability of the right quantity of a specific type of service. This might include nursing support at home; standard care as well as re-ablement based domiciliary care; therapy from physiotherapists; occupational therapists and others; intermediate care bedded facilities with the best support; as well as support from General Practitioners managing medication and overseeing the treatment of the condition(s).

Commissioners need to be aware of the number of short-term beds and hours of short-term care that will be required to manage the flow. They will need to be aware of the availability of therapists and nurses to ensure the opportunities for recovery are maximised for each patient. One of the critical issues facing the health services across the United Kingdom is a serious shortfall of this support available to people in the community that is increasing hospital admissions and reducing recovery post discharge.

A final consideration for patients at the point of discharge is the best type of care that might support their move to greater independence. The wide use of re-ablement based domiciliary care may not always be the right support, depending on the person and their condition. Older people, who have had elective surgery, and where the recovery period can be planned in advance, may be able to manage their own recovery with the support of a physiotherapist or an occupational therapist. This is likely to entail the patient undertaking a programme of exercises prior to admission as well as continuing the programme as part of their recovery. These patients should not require the additional domiciliary care re-ablement programme, and if they

¹³ <http://www.local.gov.uk/documents/10180/11779/LGA+Adult+Social+Care+Efficiency+Programme>

¹⁴ Report for East Midlands Social Care (ADASS) by Rachel Ayling

¹⁵ Findings from unpublished work of John Bolton with a number of local authorities across the UK as cited earlier in this report

do need support, a small amount of “ordinary” domiciliary care should suffice. (Usually the service should only be in place for a couple of weeks whilst the person manages their own recovery. This will of course depend on the patient and their personal circumstances). The evidence from the LGA programme suggested that this might apply to as many as 50% of those discharged from hospital. There needs to be a careful assessment made by the therapists for those older people who ought to recover with a programme from them and those who may require the additional service (and associated cost) of domiciliary care based re-ablement.

A similar consideration is needed as to whether a person will need a bedded facility from which their recovery should be managed (and for how long) and to what extent a person can be best helped to recover at home. There is a risk of over-use of bedded facilities post discharge where there is more likely to be a speedier recovery for the person in their own home. In the end this decision has to be best made by the therapists who have worked with the patients in hospital. If a person is placed within a rehabilitation bed it is best that their therapeutic treatment is completed alongside an assessment of future need within six weeks (there may be some conditions that require a longer period to maximise recovery). The prime aim should always start with a view that the person is helped to return home.

Our suggested objectives for managing demand from hospitals are:

Objective 2

The council working with NHS Partners have in place a set of arrangements that allow for the speedy discharge of patients from hospital and achieves the best possible outcomes for those people.

Objective 3

There is timely, targeted and effective use of re-ablement and rehabilitation that has a focus on enabling independence and self-management and avoiding the over-prescription of care.

Objective 4

Health professionals managing medical conditions and delivering therapeutic help work closely with those offering re-ablement/rehabilitation to deliver the persons outcomes.

Objective 5

There are sufficient intermediate care type services available in the community to support discharge

Performance Measures

For a council wanting to manage performance against these objectives we would suggest consideration of the following measures:

- The % of patients who, at the point of discharge, have received an appropriate service within 48 hours.

Key services are able to respond within 48 hours of being notified that their help is required.

- The proportion of people in any one week waiting for a service that has been agreed by the patient and the multi-disciplinary discharge team.

This figure should preferably be close to zero (with a record kept of reason)

- The proportion of people who are delayed from discharge when they are medically fit.

This figure should be close to zero.

- The proportion of patients who are discharged to a permanent residential care bed without any opportunity for short-term recovery.
This figure should preferably be close to zero.
- The proportion of patients who return home after a short-term period (no more than six weeks) in a residential care bed.
This figure should be close to 75%.
- The proportion of people who receive long-term care after a period of short-term / re-ablement based care (this could be either a therapy led programme or domiciliary care based re-ablement).
This figure should preferably be close to 25%
- The proportion of older people who are discharged from hospital with no formal care services after two weeks/six weeks.

Step 3 - Effective short-term interventions for people from the community

How are the initial offers of help to people designed and can they respond with short term help that may reduce or eliminate the need for longer-term solutions e.g. access to re-ablement?

Rationale

The way in which the care system responds to a person's set of needs in the first instance can make a great deal of difference to the longer-term outcome for the person and an impact on future service demands. It is important that the care system does not rush to find solutions for people within formal care where there may be other options or solutions. Most people come to social care when they are in some kind of crisis. In some instances, the response must not be to assess the person when they are in their crisis but to find a way of holding the person to address any immediate risks whilst options for the future are tried and explored. This is particularly important when it comes to assessing people for residential care. A person's needs in their immediate crisis may signify that an admission to residential care is an appropriate solution.

However, it is likely in about a third of these cases that a period to sort out the crisis; some support with recovery and re-ablement; a review of the medical help being offered and a period of close monitoring may find solutions to support the person to remain in their own home (which is what most older people report as the outcome they are seeking). Medical professionals who are working alongside social care should be discouraged from requesting assessments for a specific service e.g. for residential care. They should instead be encouraged to seek a social care (and other) assessment. Though the patterns of admissions to residential care have changed in the past decades (with the numbers of people funded by the state either reducing or staying the same) there are still too many people being placed permanently before other options, including their recovery, have been explored. The demands from the acute sector can dominate the overall demands on social care if this is not well managed. It is important though that people who are referred through the community are given the same range of short-term support as those who may have been referred from the hospital. Access to domiciliary care re-ablement is as important for those with care needs in the community as it is to those being discharged from hospital. But the concept of re-ablement should not just be an approach for older people. It should also be available as an approach to assisting anyone with social care needs.

Before anyone is assessed for their long-term needs there needs to be a period in which they can be assisted in an appropriate way to help manage their long term condition. All of the approaches listed below are an important part of a holistic social care system:

- The Local Government Association Report on efficiencies¹⁶ for adults with a learning disability highlights the approach in Kent where their 'pathway to independence service' is offered to all those with a more moderate level of disability (about one third of people in the current service).
- In Coventry ten years ago, the council developed a "re-ablement" service for all new customers who had acquired a disability. The service assisted people to develop the skills required to adapt their lives and the equipment that could support this.

The recovery model in mental health services has demonstrated that people with a mental health problem can be assisted to self-manage their condition with support from peers.

For every person who identified with a current (eligible) set of needs there must be a consideration of the short-term assistance that could be offered to assist them in regaining independence or to better manage their condition. If 25-33% of people who have approached the council for help are found to be likely to need on-going help then these are the people that should be targeted with the appropriate intervention/support. At least two thirds of these people are likely to benefit from the help they receive to an extent that their care needs are reduced.

There are additional issues in relation to how people are assessed. The first is the evidence that suggests different people undertaking assessments have very different solutions to meet people's needs and some assessments lead to over-provision (as shown in the LGA Adult Care Efficiency Programme). The evidence for this is particularly a phenomenon in relation to packages of care assessed when someone is ready for hospital discharge. (The Newton Study for the LGA¹⁷ showed one in five older people were over assessed for the care they required which is cited above). Similar over provision has been found in both levels of domiciliary care for older people and care and support for some younger adults with disabilities.

One area where the over assessment of need is demonstrated is the proportion of people receiving less than 10 hours of domiciliary care. Sometimes the assessment of domiciliary care to meet lower levels of needs can be quite inappropriate. The evidence from McMaster University (Canada 2008)¹⁸ shows that a little bit of formal help may not always be the best way to assist someone; in fact for some older people it will accelerate the need for more help. Work undertaken in some Councils shows that there may be a better solution for about 50% of older people who are in receipt of lower levels of domiciliary care. For example, if an older person is socially isolated there are better ways of tackling the isolation through helping people link into their communities; resolve difference with their families or through volunteers / volunteering. Another area where domiciliary care may be proscribed is where a person is "at some risk" from a fall or there are general concerns about a person's well-being. In each case there may be a better solution ranging from taking more exercise to reduce risks to using telecare for the rare occasions when a risky event takes place.

¹⁶ <http://www.local.gov.uk/documents/10180/6869714/Learning+disabilities+report+-+V2.pdf/02a8813f-fa27-4449-81a0-dfc04df7c943>

¹⁷ Health and Social Care Efficiency on LGA website: http://www.local.gov.uk/productivity/-/journal_content/56/10180/3371097?_56_INSTANCE_0000_templateId=ARTICLE

¹⁸ Markle-Reid M, Browne G, Weir R, Gafni A, Roberts J, Henderson S. Seniors at risk: The association between the 6-month use of publicly funded home support services and quality of life and use of health services for older people. Canadian Journal on Aging. 2008; 27(2);207-224.

Finally, we should make a comment on the changing nature of social care in relation to the increasing proportion of older people assessed as able to fund part or all of their own care costs. Every person is entitled to an assessment of their need irrespective of their income. As we enter a period where people have gained higher pensions than previous generations, and these same people have assets in the form of housing, there are more people who will be asked to fund their own care (under the current arrangements in England)¹⁹. This will mean that both in residential care and for domiciliary care there will be a private market where people may choose when they are ready for care. This does mean that some people enter their care setting prematurely (in relation to their overall needs). In some places these people also run out of resources whilst receiving expensive care, passing the continuing costs onto the council. Some Councils have started to take action to manage this better. The common approach is to link with General Practitioners to ensure that they do not advise older people to move to residential care when there may be better alternatives.

Objective 6

There is timely, targeted and effective use of re-ablement and rehabilitation that has a focus on enabling independence and self-management, and avoiding the over-prescription of care.

Performance Measures:

For a council wanting to manage performance against this objective, we would suggest consideration of the following measures:

- The proportion of older people who receive less than 10 hours of domiciliary care (as a proportion of all older people receiving domiciliary care).

The figure should preferably be no more than 15%.

- The proportion of older people assessed as having care needs, who were offered a re-ablement based service. Either this could be a therapy led assessment with help offered or domiciliary care based re-ablement.

This figure should preferably be more than 70%.

- The proportion of adults with a learning disability who should be offered a programme to assist them achieve a higher level of independence.

This figure should preferably be more than 30% (with 100% of those with moderate – low needs).

- The proportion of adults who have a newly acquired disability who should be offered an assessment to help them maximise their opportunities for independent living.

This figure should preferably be over 90%.

- The proportion of adults recovering from mental ill-health who should have a programme to support their long term recovery that includes helping to both self-manage their symptoms and includes peer-support.

This figure should preferably be over 70%

- The proportion of those who are assessed as needing domiciliary care should receive their care within 48 hours of the assessment being completed.

This figure should preferably be over 90%.

¹⁹ There is a different funding arrangement in Wales where there is a cap on the maximum a person can pay for domiciliary care that is currently at £70.00 per week.

Step 4 – Designing the care system for people with long term care and support needs

How does the way in which we assist people help them gain opportunities for greater independence in the longer term?

How do we assist people to live better with their long-term conditions when they receive longer-term assistance?

Rationale

When people are assessed as having longer term care needs there are important considerations as to how their needs are met. Every person within the formal care system should have a care plan which seeks to maximise their opportunities for independence. Discussions on the care plan should fully involve the person themselves and be agreed with the informal carer (where they are playing an active part in the delivery of care).

One of the recent developments in social care is a growing realisation that our traditional approach to assessment of needs has been developed with a focus on what people *cannot* do for themselves (the deficit model) rather than on their abilities, their network and the potential they may have (the asset model). Some Councils report that their assessments are now much more focussed on what people can do for themselves, how their families, neighbours, friends and the wider community can assist them, and how any formal care should support and build on existing circumstances rather than take everything away from the person. This approach to assessment can have a big impact on the size and the type of care package a person might require. It does of course lend itself much more to the delivery of a personal budget than a formal service - such as domiciliary or day care.

The progression planning introduced into Darlington²⁰ shows the potential for every person with a learning disability to progress to a greater degree of independence. For those with challenging behaviours they may need psychological help to manage their behaviours; for those who have become dependent on institutional care they may be assisted to move to independent living; for those in independent living they may learn more skills to maximise their opportunities with the likely outcome that they will need less direct care and support e.g. not requiring night time support where a simple community alarm system will do.

Those with disabilities support to help gain skills of greater independence should always be the desired outcome and with modern technology to assist people alongside developments in prosthetics and rehabilitation some people will require less formal care. One issue that some people with disabilities face is their sense of loss relating to their condition. Psychological support to help people mourn the loss and live with their condition may be an important part of the help on offer.

For some younger adults with longer-term care needs, including those with learning disabilities, there is the additional challenge of whether residential care is the right option for many people who have ended up in a long-term placement. There are significant variations between Councils as to whether a person is supported in the community or in a residential care place. Some Councils argue that residential care can be the least expensive and at the same time the best option (though this is contrary to any previous government policy). This ought not to be the case. For example, approximately £100 (this figure varies from placement to placement) a week cost to any placement that is not met by the council if a person is supported in their own tenancy (the housing cost). Some places will use that £100 to fund more care or support staff, though it is questionable whether that is always necessary, and in some places it has built a

²⁰ <http://www.local.gov.uk/documents/10180/6869714/Learning+disabilities+report+-+V2.pdf/02a8813f-fa27-4449-81a0-dfc04df7c943>

dependency in the care setting that has only increased people's needs. In all forms of supported housing, including extra-care housing for older people²¹, it is possible either to create an institutional setting that creates dependency on care or to create a setting that helps to promote people's independence. The policy direction has for some time stated in most cases people should be supported in their own tenancies. This may need to be shared tenancies to help alleviate some of the costs. Demand for residential care can be met through offering community based alternatives. It is also important that these alternatives continue to help people live independent lives in the community as much as is reasonable and safe.

Fully understanding an older person's physical and mental condition is of course important to identifying their care needs. Older people, where appropriate, should be encouraged to take exercise, manage their diet, including moderating their intake of alcohol, and look after their well-being. For some they will need much more support e.g. those people living with dementia. This cohort can be assisted to live with their disease/condition. The emergence of assistive technology; the role of mind as well as physical exercise; the importance of diet and the support to carers can all help sustain older people within their own homes for a longer period than in the past.

There are a number of studies²² that demonstrate even when an older person has been defined as being "frail" it may be possible to reduce their levels of frailty. The underlying approach follows a process of delaying decline by reactivation through targeted exercises, the proportional use of assistive technology to compensate for decline, and the timely introduction of care/services only when these become evidentially necessary²³. Each stage of decline is approached differently, and currently around 170 distinct difficulties can be addressed. The Aston University Research²⁴ project commissioned by the Extra Care Charitable Trust demonstrated that older people offered help with diet; exercise and activity (a "well-being" programme) could increase their strength and improve their health reducing their levels of frailty and their use of both NHS and social care services.

In essence, it is important that the principles of "promoting independence" or "the progression model" are used for the way in which all people within the care system are offered long-term assistance. The way in which care is delivered can lead to people becoming unnecessarily reliant on the care they receive. It is the way that the care is delivered that creates the dependency and the higher levels of need not the conditions or the needs of the person alone.

Finally, it is important to consider another feature of the care system - the role and function of the annual review of the customer and the care they are receiving. In many Councils these reviews are treated as a simple process to check everything is going well for the customer. Recommendations to reduce the care a person needs are rare. The key to the approach lies in the nature of the care plan that has been set for the customer. The aim of the care plan should be to look at the help that is being offered to the person which will help them gain, regain or retain their levels of independence (in line with the messages from this paper). The review should then focus on whether the help being offered has assisted the person with these key objectives. Any new care plan agreed should focus on these as the key outcomes that should

²¹ A guideline suggested by me is that no one should receive more than 15 hours of care in a week within an extra-care housing scheme.

²² Jagger, Kingston Australian Women's Longitudinal study (not yet published)
Peeters, G et al. "WHO A life-course perspective on physical functioning in women" Sept 2013
Hoenig Role of AT in community dwelling elders in Florida

Marco Pahor MD; Jack M Guralnik et al. "Effect of structured physical activity on prevention of major mobility disability in older adults: The LIFE study RCT." JAMA 2014

²³ Software developed by the organisation ADL Smartcare.

²⁴ ExtraCare Project - Aston University www.aston.ac.uk/lhs/research/centres-facilities/archa/extracare-project A research project between Aston Research Centre for Healthy Ageing (ARCHA) and the ExtraCare Charitable Trust.

be expected from the provider of care. Much of the information in the performance indicators below is gathered from the information collated in the review process.

Objective 7

People with long-term conditions have a care and support plan with a focus on achieving the maximum possible independence (as is realistic and possible for their individual circumstances). Plans are regularly reviewed based on outcomes achieved.

Performance Measures

For a council wanting to manage performance against these objectives we would suggest consideration of the following measures as performance indicators for those with longer-term care needs:

- The proportion of older people receiving longer term care whose care needs have decreased from their initial assessment/latest review.
This figure should preferably be around 15% of the older people supported.
- The proportion of younger adults receiving longer term care who care needs may have decreased from their last review.
This figure should preferably be around 66% of all younger adults receiving care and support.
- The proportion of older people receiving longer-term care whose needs have increased since their initial assessment or latest review?
This figure should preferably be no more than 25% of the total receiving care
- The proportion of older people (without a diagnosis of dementia) who enter residential care after receiving domiciliary care.
This figure should preferably be at a maximum of 20% of those receiving care.
- The proportion of older people with a diagnosis of dementia who enter residential care after receiving domiciliary care.
This figure should preferably be at a maximum of 20% of those receiving care
- The proportion of older people with a requirement for palliative care who died at home.
This figure should preferably be at least 75% of those who stated that they wanted to die at home.
- The proportion of younger adults receiving longer-term services who are living in registered residential care.
This figure should preferably be less than 10% of those who need care and support.
- Total spend by a council on all adult residential care.
This figure should preferably be no more than 30% of the gross adult social care budget.
- The proportion of older people living in extra-care housing who are receiving more than 14 hours of care.
This figure should preferably be no more than 10% of those living in an extra-care facility at any one time.

Step 5 - Developing a workforce to manage demand

To what extent has the work force been commissioned/managed (trained) to deliver the best possible outcomes for citizens at all of these different levels?

Rationale

A key factor not explored in the earlier paper was the importance of having the right workforce to assist in delivering the suggested set of measures. One of the biggest losses from all of the cuts that have hit the sector in recent years is that of training and development of staff. It is ironic that given the scale of the cuts there are more staff working in the care sector than at any previous time. Many of these people work part-time and on very low wages. The care sector has become unskilled/de-skilled despite tremendous passion and goodwill from care staff. It is important that if the sector is to deliver the outcomes for customers that this paper might expect, staff need to be trained and rewarded for the outcomes they then deliver. Financially, this may be very difficult in the current climate – for even if demand was managed better – freeing up resources, – there is still insufficient money in the sector to meet all of its challenges²⁵.

However, if demand was better managed, it appears there would be sufficient capacity in the sector to meet current needs. With this rationale in mind, the following objective is offered:

Objective 9

The workforce are fully trained and supported to work with people needing social care which fits with the ethos and principles of the organisation

Workforce Skills

Whilst the objective does not have a set of specific performance measures to evidence the effectiveness of arrangements in this area, Councils and providers of commissioned and non-commissioned services should regularly explore the extent to which the workforce deploys the following set of skills and expertise:

- Staff on the front door understand the options in the community and to where people could be sign-posted and be able to see the outcomes of their work.
- Staff in the hospital and those working in the community in assessment and care management are able to assess for the most appropriate intervention that will assist a person maximise their opportunities for independence post-discharge.
- Staff working in the post-hospital discharge services have the skills to assist people in reaching their maximum potential.
- Staff working in domiciliary care re-ablement services understand the ways in which they can help a person regain confidence and skills for daily living.
- Staff working in the community understand the various conditions that people might have and the best way to assist those people, both to live with their long-term conditions and reduce their need for longer term services, where appropriate.
- Staff in residential and nursing care understand the nature of the person's needs and how these can be assisted.
- All staff understand how to manage risk in order to get the right balance between assisting people to gain independence and protecting people from harm.

²⁵ What are the opportunities and threats for further savings in adult social care-
<http://ipc.brookes.ac.uk/publications.html>

For many, this requires both a significant cultural change and a new skill set. Staff will need to learn how their care can lead people to greater dependency and how they can manage risk to assist people move towards greater independence. At the same time they will need to understand each specific condition and the best way of assisting the person as an individual. One of the reasons why demand has not been as well managed in Councils, as it should have been is because insufficient attention has been paid to the training and development of staff to deliver the agenda.

Step 6 - Governance and management arrangements to sustain improvements

How are managers in the authority and commissioned providers held to account for the delivery of the desired outcomes from the care system?

Rationale

To deliver the cultural change described in this paper requires strong leadership. It is helpful when the vision and direction for social care has clarity and is supported by Members (of the Council); Senior Leaders in the Authority; partners (including NHS partners; the voluntary sector; and the main local providers) and citizens that must of course include users of the services. Setting the vision and being clear as to what that will mean for all parties is a precursor to any change programme.

Whilst many Councils will already find that they are managing demand well in a number of areas, there are usually some that still require attention. An analysis of what is working and what is not (using the tools in this paper) may help to determine where effort and energy is required from senior leaders. Once the direction is agreed and the targets that might be achieved are set there must a performance management set of arrangements put in place. There should be a minimum of quarterly meetings that review progress against the targets and holds managers to account for their performance is required. The meeting should be chaired by a senior manager with sufficient authority to ensure that actions are being taken to drive forward the required progress. Targets can be reviewed and revised in order to be realistic given local conditions but the overall strategic direction should not be changed without a thorough examination of the evidence available (both locally and nationally).

Councils might consider establishing local discussion forums to enable practitioners to consider and develop the skills they require to promote the policies. These should operate in parallel to the performance management arrangements that hold managers to account for their delivery. Where it is appropriate, these should be for staff across the multi-disciplinary team and may involve providers of care to both contribute to and enhance their knowledge. These should sit alongside the more formal “panel meetings” that are often in place to give an oversight on the care that is being agreed for higher cost packages for individuals.

Of course it is not just the local authority that provides the key outcomes for people in the care system. Providers of care need also to be held to account for the outcomes they deliver for local people receiving care. At its simplest, this involves considering whether providers are creating dependency on the services they provide or are they supporting people to achieve greater independence? The logic of this paper is that both Councils and providers ought to know the answer to this question.

This could be measured from key performance indicators set out within local contracts. The measures might include the following:

Objective 10

The collation and analysis of performance data (activity, finance and outcomes) supports an understanding of whether there has been an impact on the delivery of outcomes and the management of demand:

- The proportion of older people receiving on-going domiciliary care that move on to residential care.
- The proportion of older people receiving on-going domiciliary care whose needs are reduced over time.
- The proportion of younger adults in residential care who move on to greater independence.
- The proportion of younger adults who are supported in the community whose needs reduce over time?
- The proportion of people with a learning disability who are supported to live more independently over time.

The list has a close parallel to those that the council will measure of the outcomes achieved across the care system. Each provider can be held to account for their contribution to the overall outcomes. It is best that this approach is shared with providers and the indicators developed collaboratively. Experience related to this approach has indicated that some of the better providers already collect their own information on outcomes (usually related to customer satisfaction with services) and these additional indicators can be added to the existing suite already in place.

The objective does not have a set of specific performance measures to evidence the effectiveness of arrangements in this area. However, organisations should use the following “standards” to assess their governance and performance management arrangements:

- There is an agreed evidence-based understanding at a strategic level of the drivers on demand for care and support.
- There are governance structures in place that agree and regularly review and monitor the delivery of a shared health and social care vision and strategic priorities, with a focus on delivering better outcomes to manage demand.
- The governance structures include representation from other partner organisations.
- There is clear alignment between strategic vision and priorities, and operational objectives, quality standards and plans.
- Operational managers regularly monitor and review their service objectives, quality standards and plans and report performance exceptions as required.
- There has been an analysis of all care pathways and processes to understand which, and which elements of them, are effective or not.
- The qualitative and quantitative data collected is appropriate and of a sufficient quality to inform operational and strategic planning and performance review.
- Users and carers are actively involved in the monitoring of services, as well as peer review of services.

Part Two – Managing Demand – Managing Performance

Part One suggests agreeing a set of strategic objectives that specifically focus on managing demand requires an accompanying group of performance measures and locally agreed targets. In Part Two, we suggest that in addition to objectives and measures, organisations consider their performance management culture and processes that are fundamental to effective performance management.

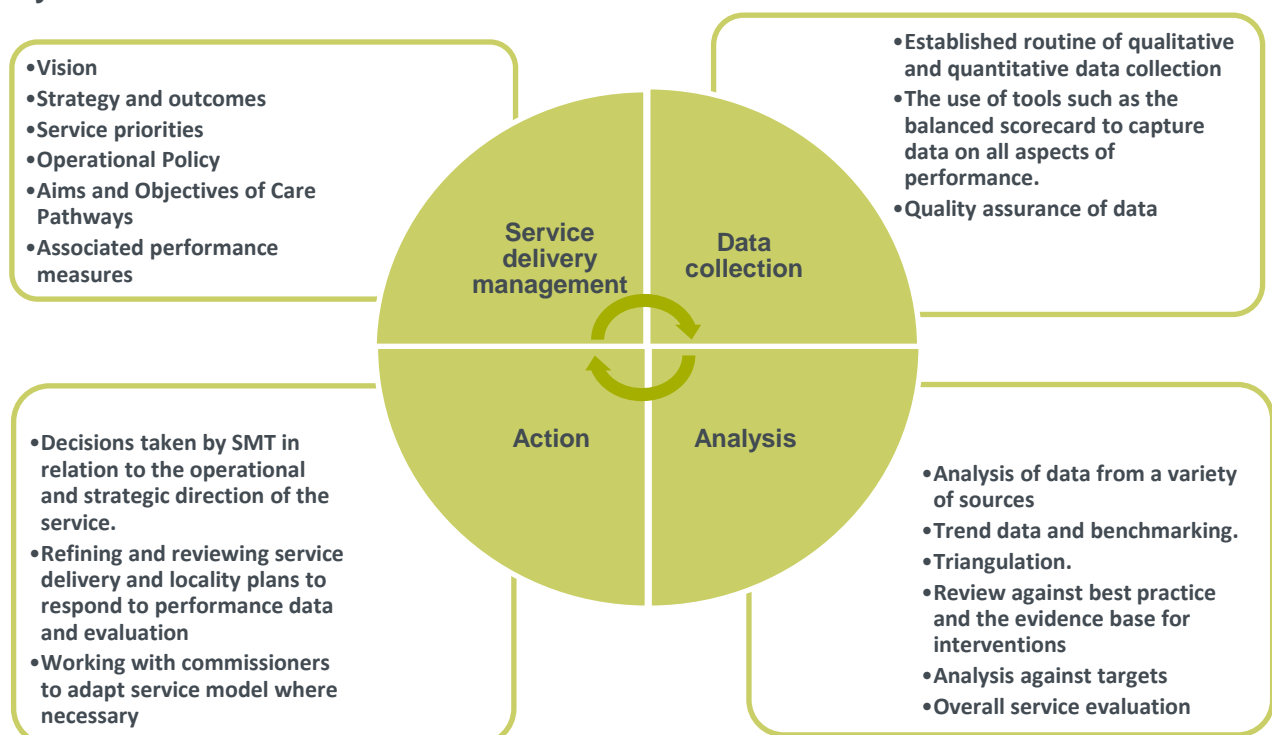
The past 10 years or more has seen a significant shift in policy expectations for public care performance monitoring, quality assurance and measuring and monitoring the impact of services on service users (and patients) through outcomes measurement. This trend is even more vital for the foreseeable future for reasons detailed in Part One and, in particular, for organisational arrangements to have effective evidence in its performance in:

- delivering outcomes;
- demonstrating high quality care;
- financial efficiencies;
- developing a sustainable workforce to underpin the above.

Developing a performance monitoring approach and framework that can capture this information easily and robustly will be critical for organisations over the next period of time. So where does this need to start?

Good performance evaluation is a key tool in developing a cycle of continuous improvement within organisations, enabling managers to monitor and adapt their service model so that it delivers its intended outcomes (see Figure 1) even when the external and internal environment changes.

Figure 1 - Performance Evaluation – the basic principles of a ‘continuous improvement’ cycle



The effectiveness of this approach is dependent on:

- robust service delivery and management processes such as the vision and objectives for the service being well understood and shared across delivery units or teams;
- the development of performance measures which can capture information on how well the service is performing at any one time (see also balanced scorecard below) and which reflect the operations and processes of the service as well as the clinical and wellbeing outcomes it is trying to achieve;
- data collection activities which allow business managers to establish a set of robust quantitative and qualitative measures across the service which can be captured routinely and used to compare performance over time;
- recognition that to get a true picture of performance of a service, data will need to come from a range of different sources and be triangulated in order to understand weaknesses and strengths in performance;
- a feedback loop that uses this information to inform decisions taken operationally and strategically across the service and is used to refine and improve provision where possible, and feedback into the performance cycle again.

Creating a performance management culture

Good performance evaluation frameworks in health and social care organisations provide essential support for the planning and decision-making processes, which underpin service delivery such as budgeting, managing capacity, process improvement and benchmarking.

They are systems that track selected performance measures overtime, collating, triangulating and analysing data and information to provide detailed information on how well the service is meeting its original aims and objectives, whilst making judgements...

“... about the arrangements organisations use to get the right things done successfully. The essence of performance management is the organisation of work to achieve optimum results, and this involves attention to both work processes and people.”

Mike Walters, The Performance Management Handbook

Typically, the characteristics of a good performance management culture include:

Characteristic	Design arrangement or activity
Openness to external challenge	Integrating learning from external inspection and audit
Managers focus energy on what is done in context of community vision/ objectives	Clear business plans and quality management arrangements
Staff see direct link between what they do and how it benefits the community	The link between business plans, quality assurance and personal development plans is made clear and reinforced through regular appraisals
Managers facilitate discussions on how performance can be improved, inviting contribution from staff	Staff involvement in the development of business plans and their regular monitoring and reviewing activities
Meetings encourage problem-solving, challenge and support	Regular Performance Review Meetings

Performance evaluation and reporting naturally sits within a business and performance team remit. In practice, however, competing priorities and reduced capacity within such teams mean that over recent years capacity in organisations to put in the time and thought into designing detailed performance management arrangements has become limited. A potential risk of this position is that organisations continue to have a performance systems (and governance arrangements) which is driven by what is easiest to measure, or the IT systems which underpin it, rather than strategically planning what is needed at an operational level and what might be needed by to focus on understanding the delivery of outcomes and the management of demand.

IPC suggest that in assessing the culture and arrangements for effective performance management to deliver outcomes and manage demand, organisations should identify suitable evidence in their organisations that they have:

1. an agreed evidence-based understanding at a strategic level of the drivers on demand for care and support;
2. governance structures in place which agree and regularly review and monitor the delivery of a shared health and social care vision and strategic priorities, with a focus on delivering better outcomes to manage demand;
3. governance structures include representation from other partner organisations;
4. a clear alignment between strategic vision and priorities, and operational objectives, quality standards and plans;
5. operational managers regularly monitor and review their service objectives, quality standards and plans and report performance exceptions as required;
6. an analysis of all care pathways and processes to understand which, and which elements of them, are effective or not;
7. the qualitative and quantitative data collected is appropriate of a sufficient quality to inform operational and strategic planning and performance review;
8. there is the active involvement of users and carers in the monitoring of services, as well as peer review of services.

There is unlikely to be new money to invest in services and the push for greater efficiencies continues with pace, whilst potential reconfigurations of services in line with the sustainability and transformation plans are highly likely. IPC suggests shifting the focus of performance monitoring from a reactive framework to one, which can support strategic and financial planning and demand management in the future. However, conversations need to centre on what is most practical given the current financial and political environment (immediate to short term actions), and what can be considered as good investment in the longer term for the service.

Whatever the decisions taken on which option to pursue, it should:

- enable priorities to be monitored and updated on a regular basis;
- enable managers and their teams to identify what they need to do to implement the priorities in their area;
- reflect core business (Service Objectives) as well as identifies the impact priorities will have on this;
- ensure any risks, issues, blocks to implementation are identified and managed proactively;
- have very clear actions so staff can commit to a course of action;
- enable individual staff to identify and take responsibility for what they need to do.
- identify staff development and training needs;
- identify achievements – share what works well / solutions;

- generate the right / robust information and conversations across the system so that you can work together to implement changes;
- ensure that co-dependencies are reflected – work together before plans are finalised and agree interdependencies;
- be written in a language that is understandable and avoids blocks;
- be co-ordinated – has a clear timetable with clear accountabilities;
- be a tool that can enable managers to take control of the performance of their service, be proactive rather than defensive;
- be not just about producing a document – it is the process of discussion and agreement that is important.

Conclusion

Taking the total picture from this paper (and the earlier paper on Managing and Predicting demand) one might come to a conclusion that it is the outcomes of every intervention/support offered that are the key measures to the success or otherwise in managing demand (as far as that is able) within the care system. It is this consideration that has also led many to consider that all of the care system should be based on outcomes for the customer. Though in the model put forward in this paper there is a very specific approach that focusses on outcomes that help promote independence/reduce need for care. For those who do want to consider “outcome based commissioning” they might want also to look at the issues in the Institute of Public Care Papers: Discussion papers on Domiciliary Care Commissioning and Procurement.²⁶

The measures cited in this paper could also be used to look at how the whole care system is delivering for its customers. In particular, providers may need to be held to account for the range of outcomes they deliver as well as assessment and care management staff and commissioners. It is, however, the commissioners who have to create the environment and the range of services that are required to get the best from the total system.

The report suggests 24 indicators (summarised in Appendix 1) and the underpinning characteristics of an effective performance management approach that might assist in understanding whether demand is being managed or not. As with all indicators these are guides to where things appear to be working in the system and where they are not. They do not provide answers in themselves; rather they direct managers/ commissioners and others to look at where weaknesses may appear. The challenge is how people deal with those weaknesses.

²⁶ http://ipc.brookes.ac.uk/publications/Wales_domiciliary_care_commissioning_and_procurement.html

Appendix 1 – Objectives and Performance Measures

Step 1 - Managing Demand through the Front Door of the Council <i>How is the front of the service set up in relation to handling initial enquiries and how many of these can be resolved by the staff who handle them?</i>		
Objective	Suggested Performance Indicator	Suggested Target
Objective 1 There is an effective council front door for finding solutions for people and their problems that can demonstrate its impact in terms of diversions from formal care and delivering good outcomes.	1.1 The % of people who have approached the council for help with adult care (or an agency commissioned by the council for that purpose) who go onto receive a full social care assessment.	The figure should preferably be circa 25% of the new enquiries from the community ²⁷ . (There are a number of variable factors here so this may need to be revised in particular circumstances but might be linked to the indicator below. It may also be considering reviewing arrangements if performance is significantly higher than 25%).
	1.2 The % of people who have received a full assessment (from the 25% of people cited above) who then go on to receive a package of care.	This figure should be 90% - though the initial service may be help that supports recovery, rehabilitation, recuperation or reablement. (See the next section)

²⁷ This figure (and the one below) does not include requests for help from acute hospitals

Step 2 - Managing Demand from the Acute Hospitals <i>How the response from the acute hospital is managed and what are the outcomes for older people?</i>		
Objective	Suggested Performance Indicator	Suggested Target
Objective 2 The council working with NHS partners have in place a set of arrangements that allow for the speedy discharge of patients from hospital and achieves the best possible outcomes for those people. Objective 3 There is timely, targeted and effective use of re-ablement and rehabilitation that has a focus on enabling independence and self-management, and avoiding the over-prescription of care. Objective 4 Health professionals managing medical conditions and delivering therapeutic help work closely with those offering re-ablement/rehabilitation to deliver the persons outcomes. Objective 5 There are sufficient intermediate care type services available in the community to support discharge.	2.1 The % of patients who at the point of discharge have received an appropriate service within 48 hours.	Key services are able to respond within 48 hours of being notified that their help is required.
	2.2 The proportion of people in any week who are waiting for a service that has been agreed by the patient and the multi-disciplinary discharge team.	This figure should preferably be close to zero (with a record kept of reason).
	2.3 The proportion of people who are delayed from discharge when they are medically fit.	This figure should be close to zero.
	2.4 The proportion of patients who are discharged to a permanent residential care bed without any opportunity for short-term recovery.	This figure should preferably be close to zero
	2.5 The proportion of patients who return home after a short-term period (no more than six weeks) in a residential care bed.	This figure should be close to 75%.
	2.6 The proportion of people who receive long-term care after a period of short-term / re-ablement based care (this could be either a therapy led programme or domiciliary care based re-ablement)	This figure should preferably be close to 25%.
	2.7 The proportion of older people who are discharged from hospital with no formal care services after two weeks/six weeks.	These figures should preferably be close to 40%/66%.

Step 3 - Effective short-term interventions for people from the community <i>How are the initial offers of help to people designed and can they respond with short term help that may reduce or eliminate the need for longer-term solutions e.g. access to re-ablement?</i>		
Objective	Suggested Performance Indicator	Suggested Target
Objective 6 There is timely, targeted and effective use of re-ablement and rehabilitation that has a focus on enabling independence and self-management, and avoiding the over-prescription of care.	3.1 The proportion of older people who receive less than 10 hours of domiciliary care (as a proportion of all older people receiving domiciliary care).	The figure should preferably be no more than 15%.
	3.2 The proportion of older people who are assessed as having care needs, who were offered a re-ablement based service. Either this could be a therapy led assessment with help offered or domiciliary care based re-ablement.	This figure should preferably be more than 70%.
	3.3 The proportion of adults with a learning disability who should be offered a programme to assist them achieve a higher level of independence.	This figure should preferably be more than 30% (with 100% of those with moderate – low needs).
	3.4 The proportion of adults who have a newly acquired disability who should be offered an assessment to help them maximise their opportunities for independent living.	This figure should preferably be over 90%.
	3.5 The proportion of adults recovering from mental ill-health who should have a programme to support their long term recovery which includes helping to both self-manage their symptoms and includes peer-support.	This figure should preferably be over 70%.
	3.6 The proportion of those who are assessed as needing domiciliary care should receive their care within 48 hours of the assessment being completed.	This figure should preferably be over 90%.

Step 4 - Designing the care system for people with long term care and support needs <i>How does the way in which we assist people help them gain opportunities for greater independence in the longer term?</i> <i>How do we assist people to live better with their long-term conditions when they receive longer-term assistance?</i>		
Objective	Suggested Performance Indicator	Suggested Target
Objective 7 People with long-term conditions have a care and support plan that has a focus on achieving the maximum possible independence (as is realistic and possible for their individual circumstances). Plans are regularly reviewed based on outcomes achieved.	4.1 The proportion of older people receiving longer-term care whose care needs have decreased from their initial assessment/latest review.	This figure should preferably be around 15% of the older people supported.
	4.2 The proportion of younger adults receiving longer-term care who care needs may have decreased from their last review.	This figure should preferably be around 66% of all younger adults receiving care and support.
	4.3 The proportion of older people receiving longer term care whose needs have increased since their initial assessment or latest review?	This figure should preferably be no more than 25% of the total receiving care.
	4.4 The proportion of older people (without a diagnosis of dementia) who enter residential care after receiving domiciliary care.	This figure should preferably be at a maximum of 20% of those receiving care.
	4.5 The proportion of older people with a diagnosis of dementia who enter residential care after receiving domiciliary care.	This figure should preferably be at a maximum of 20% of those receiving care.
	4.6 The proportion of older people with a requirement for palliative care who died at home.	This figure should preferably be at least 75% of those who stated that they wanted to die at home.
	4.7 The proportion of younger adults receiving longer-term services who are living in registered residential care.	This figure should preferably be less than 10% of those who need care and support.
	4.8 Total spend by a council on all adult residential care.	This figure should preferably be no more than 30% of the gross adult social care budget.
	4.9 The proportion of older people living in extra-care housing who are receiving more than 14 hours of care.	This figure should preferably be no more than 10% of those living in an extra-care facility at any one time.

Step 5 - Developing a workforce to manage demand <i>To what extent has the work force been commissioned/managed (trained) to deliver the best possible outcomes for citizens at all of these different levels?</i>	
Objective	Skills and Experience
Objective 9 The workforce are fully trained and supported to work with people needing social care which fits with the ethos and principles of the organisation	a) Staff on the front door understand the options in the community and to where people could be sign-posted and be able to see the outcomes of their work.
	b) Staff in the hospital and those working in the community in assessment and care management are able to assess for the most appropriate intervention that will assist a person maximise their opportunities for independence post-discharge.
	c) Staff working in the post-hospital discharge services have the skills to assist people in reaching their maximum potential.
	d) Staff working in domiciliary care re-ablement services understand the ways in which they can help a person regain confidence and skills for daily living.
	e) Staff working in the community understand the various conditions that people might have and the best way to assist those people both to live with their long-term conditions and reduce their need for longer term services, where appropriate.
	f) Staff in residential and nursing care understand the nature of the person's needs and how these can be assisted.
	g) All staff understand how to manage risk in order to get the right balance between assisting people to gain independence and protecting people from harm.

Step 6 - Governance and management arrangements to sustain improvements <i>How are managers in the authority and commissioned providers held to account for the delivery of the desired outcomes from the care system?</i>	
Objective	Good Practice Characteristics
Objective 10 The collation and analysis of performance data (activity, finance and outcomes) supports an understanding of whether there has been an impact on the delivery of outcomes and the management of demand.	a) There is an agreed evidence-based understanding at a strategic level of the drivers on demand for care and support.
	b) There are governance structures in place that agree and regularly review and monitor the delivery of a shared health and social care vision and strategic priorities, with a focus on delivering better outcomes to manage demand.
	c) The governance structures include representation from other partner organisations.
	d) There is clear alignment between strategic vision and priorities, and operational objectives, quality standards and plans.
	e) Operational managers regularly monitor and review their service objectives, quality standards and plans and report performance exceptions as required.
	f) There has been an analysis of all care pathways and processes to understand which, and which elements of them, are effective or not.
	g) The qualitative and quantitative data collected is appropriate of a sufficient quality to inform operational and strategic planning and performance review.
	h) There is the active involvement of users and carers in the monitoring of services, as well as peer review of services.